

H.A.P. COMMUNITY ACTION HEAD START PROGRAM

Date: _____

Please fill out this form as completely as possible. All information contained in this application will be kept confidential.

Child's Name: _____ Birthdate: _____ Age: _____

Parent/Guardian's Name: _____ Home Phone: _____

Contact Phone: _____

Address: _____ City: _____ County: _____

Number of people living in your house: _____ Number of people in your family: _____

Directions to your home: _____

Total **household** income before taxes for the past 12 months: _____

Total **family** income before taxes for the past 12 months: _____

If you are receiving Public Assistance, which type: OWF _____ SSI _____ Other _____

Are you homeless? _____

Are you a single parent? Yes _____ No _____ Who referred you to Head Start? _____

Would you be able to provide daily transportation for your child? Yes _____ No _____

Does your child have a suspected disability? _____ or diagnosed disability? _____

VOLUNTARY INFORMATION

A 1972 Congressional mandate requires that at least 10% of Head Start's enrollment be available for children with disabilities. You are invited to volunteer this information to assist in placement of your child in Head Start. Refusal to provide this information will not adversely affect your child's placement. Special consideration will be given to children with special needs.

Do you believe your child has a special need? Please check all concerns from the following list:

_____ **BEHAVIOR** (Tantrums, destructive, lacks energy, fearful, not able to accept limits)

_____ **SOCIALIZATION** (Doesn't play/work with others well, separation difficulties, seems left out)

_____ **SPEECH/LANGUAGE** (Unclear speech, incomplete sentences, inappropriate answers)

_____ **SELF-HELP** (Toileting difficulties, problems feeding/dressing self, cannot follow routines)

_____ **ATTENTION** (Easily distracted, short attention span, darts from task to task)

_____ **DEVELOPMENTAL ABILITIES** (Learns slowly, doesn't understand well, seems immature)

_____ **MOTOR** (Clumsy, difficulty with fastenings, using scissors, poor control of body movements)

_____ **HEARING** (favors one ear, has earaches, speaks loudly, watches faces when people talk)

_____ **VISION** (Eyes turn in/out, squints, TV/book close to face, blinks a lot, tilts head, rub eyes)

_____ **MEDICAL/HEALTH RELATED** (Serious illnesses, accidents, in hospital _____ times)

_____ **OTHER** _____

YOU WILL BE NOTIFIED IF YOUR CHILD IS ACCEPTED IN THE HEAD START PROGRAM.

If you have any questions about Head Start or need assistance in completing this application
call toll-free: 1-800-686-1093 or in Athens 592-6601.

Fold in thirds. Make sure Community Action Head Start address is showing, tape edge and mail.



Hocking - Athens - Perry
Community Action

HEAD START

**Parents-
See inside for important
news about free preschool
services for your 3 to 5
year old children!!**

POVERTY INCOME GUIDELINES

Size of family unit	Poverty guidelines 2008
1.....	\$10,400.00
2.....	\$14,000.00
3.....	\$17,600.00
4.....	\$21,200.00
5.....	\$24,800.00
6.....	\$28,400.00
7.....	\$32,000.00
8.....	\$35,600.00

For family units with more than 8 members, add \$3,600. for each additional member.

Head Start Centers located in:
Athens, Corning, Laurelville, Logan,
Nelsonville & New Lexington

Hocking-Athens-Perry Community Action
Head Start Program
3 Cardaras Drive
P.O. Box 220
Glouster, OH 45732

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